

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (152)

## CERTIFICATE OF DEATH

Reg. Dist. No. 10278-2

## 1. PLACE OF DEATH:

County

City or town

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

## 3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of

deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

10. Usual occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal. Which?)

Date thereof

Cemetery or crematory

Location

19. Funeral director

Address

19.

(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw

Immediate cause of death

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address

Date signed

1951

UNITED STATES DEPARTMENT OF JUSTICE

RECEIVED  
JUN 25 1946  
BUREAU V.A.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

10279

282

## 1. PLACE OF DEATH:

County St Marys  
 City or town Leonardtown Md  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 17 days  
 Hospital, institution, or street address where death occurred:  
St Marys Hospital  
 How long in hospital or institution? 7 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County St Marys  
 City or town Baltimore  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)  
 2. (a) if veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Daniel Webster Bowler

## 3. (b) Social Security Number

4. Sex male 5. Color or race White 6. (a) Single, married, widowed, or divorced Divorced

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) Aug 10 - 1889

8. AGE: Years 57 Months 1 Days 23 hrs. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace Chaptico St Marys Maryland  
 (Town, county, and state)

10. Usual occupation Farmer

11. Industry or business Farmer

12. Name John W. Bowler

13. Birthplace St Marys co

14. Maiden name Mary Hill

15. Birthplace St Marys co

16. Informant Ernest Bowler

Address Palmer Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 5, 1946  
 (month) (day) (year)

Cemetery or crematory Seacrest Cemetery

Location Bushwood Md

18. Funeral director W C Mathewson Sons

Address Leonardtown Md

19. 10/4 19 46 Cause  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 3 19 46 at 9:03 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 16 19 46 to Oct 3 19 46 and that I last saw him alive on Oct 3 19 46

Immediate cause of death Intestinal Obstruction DURATION 1 month

Due to Hernia 6 years

Due to \_\_\_\_\_

Other conditions Cancer of bowel 2 years

(Include pregnancy within 3 months of death)

Major findings of operations Sliding Hernia, left inguinal Date of op. Sept 6, 1946

Autopsy results \_\_\_\_\_  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of Injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE John W. Bowler M. D. or other \_\_\_\_\_

Address Leonardtown Md Date signed 10/4/46

RECEIVED

OCT 7 1946

BUREAU V &

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 108

## CERTIFICATE OF DEATH

Reg. Dist. No. 282

## 1. PLACE OF DEATH:

County St. Mary's  
 City or town Fall Tumbers  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 2 mon  
 Hospital, institution, or street address where death occurred:  
 \_\_\_\_\_  
 How long in hospital or institution? \_\_\_\_\_

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State 2nd County St. Mary's  
 City or town Fall Tumbers  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Charles Allen Briscoe

## 3. (b) Social Security Number

4. Sex M 5. Color or race C 6. (a) Single, married, widowed, or divorced \_\_\_\_\_

6. (b) Name of husband or wife \_\_\_\_\_

7. Birth date of deceased (mo., day, yr.) Aug. 16, 1946 6. (c) If alive, give age \_\_\_\_\_ years

8. AGE: Years \_\_\_\_\_ Months 2 Days 11 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace md  
 (Town, county, and state)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name Rev. Lewis Briscoe

13. Birthplace md

14. Maiden name Angelina Deaters

15. Birthplace md

16. Informant Rev. L. Briscoe

Address Fall Tumbers md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10/28/46  
 (month) (day) (year)

Cemetery or crematory St. George's

Location Tracesville md

18. Funeral director W. H. Manning Sons

Address Monaca Street, 82nd

19. 10/28/46 (Date rec'd by registrar) Registrar Bruscia

## MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 28 1946 at 39 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 27 1946 to Oct. 28 1946

and that I last saw him alive on Oct. 27 1946

Immediate cause of death \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Manner of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Frank A. Camaleri M. D. or other \_\_\_\_\_

Address Monaca Street Date signed 10/28/46



Item 681 Filed 6-30-11/1512

MARYLAND STATE DEPARTMENT OF HEALTH  
2411 N. Charles St., Baltimore 92d  
CERTIFICATE OF DEATH

10281

Reg. Dist. No. 282

1. PLACE OF DEATH:  
County St. Mary's  
City or town Leonardtown, md  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 2 days  
Hospital, institution, or street address where death occurred:  
St. Mary's Hospital  
How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)  
State md County St. Mary's  
City or town St. Georges island md  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. \_\_\_\_\_  
(If rural, give LOCATION)  
2.(a) If veteran, name war \_\_\_\_\_

3. (a) FULL NAME  
Edward Vincent Brown

3. (b) Social Security Number \_\_\_\_\_

4. Sex M. 5. Color or race W. 6. (a) Single, married, widowed, or divorced Married  
6. (b) Name of husband or wife Ellen Brown  
6. (c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) Nov-4-1870

8. AGE: Years 75 Months 11 Days 21 hrs. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace St. Marys Co. md  
(Town, county, and state)

10. Usual occupation Carpenter

11. Industry or business \_\_\_\_\_

FATHER 12. Name William Brown

13. Birthplace md

MOTHER 14. Maiden name Ellen Burroughs

15. Birthplace md

16. Informant Mrs. Helen Chesson

Address 4641 Arlington Va.

17. Burial Date thereof 10-28-46  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St. Georges island M.C. Cemetery

Location St. Georges island, md

18. Funeral director H.C. Mottlinghous Sons

Address Leonardtown, md

19. 10/28/46 46 Caualus  
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct-26-1946 19 46 at \_\_\_\_\_ M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 19 42 to Oct 26 19 46  
and that I last saw him alive on Oct 26 19 46

Immediate cause of death \_\_\_\_\_ DURATION \_\_\_\_\_

Chronic illness (Heart) 8 yrs

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions General Arteriosclerosis 10 yrs

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE RJ Brown M. D. or other \_\_\_\_\_

Address Great Mills Md Date signed 10/27/46

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



RECEIVED  
OCT 30 1946  
BUREAU V R



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 9

## CERTIFICATE OF DEATH

10282

Reg. Dist. No. 282

## 1. PLACE OF DEATH:

County St Marys  
 City or town Compton Maryland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 8 months 16 days  
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County St Marys  
 City or town Compton  
 (If outside city or town limits, write RURAL and give nearest town)

Street No. \_\_\_\_\_  
 (If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3.(a) FULL NAME

Carol Ann Browning

## 3.(b) Social Security Number

4. Sex F 5. Color or race W 6.(a) Single, married, widowed, or divorced single

6.(b) Name of husband or wife \_\_\_\_\_

6.(c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) Jan 31 - 1944

8. AGE: Years 8 Months 16 Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Rural in station patient's office Md  
 (Town, county, and state)

10. Usual occupation Baby

11. Industry or business \_\_\_\_\_

FATHER 12. Name Douglas Browning

13. Birthplace West Va

MOTHER 14. Maiden name Agnes E. Mattingly

15. Birthplace St Marys Pcu

16. Informant Douglas Browning  
 Address Compton Md

17. Burial Date thereof Oct 18 - 1946  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St Francis Xavier Cemetery

Location Compton Md

18. Funeral director W C Mattingly Sons

Address Leonardtown Md

19. 10/17/46 Caucasian  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 16 19 46 at 1230 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 14 19 46 to Oct 16 19 46 and that I last saw her alive on Oct 15 19 46

Immediate cause of death \_\_\_\_\_ DURATION

Lobar pneumonia 2 days  
 Due to pharyngitis 10 days  
 Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Bruce A. Cawaler M. D. or other \_\_\_\_\_

Address Konradtown Date signed 10/17/46

NOV 1 1946  
OCT 19 1946  
BUREAU V B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 2870

## 1. PLACE OF DEATH:

County St. Mary'sCity or town Rural Scotland  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 1 day

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County St. Mary'sCity or town Rural Scotland  
(If outside city or town limits, write RURAL and give nearest town)Street No. Fresh Pond Neck  
(If rural, give LOCATION)

2.(a) If veteran, name war:

## 3. (a) FULL NAME

Joseph Edward Bryan

## 3. (b) Social Security Number

4. Sex Male 5. Color or race Black 6. (a) Single, married, widowed, or divorced single

5. (b) Name of husband or wife:

7. Birth date of deceased (mo., day, yr.) Oct. 28 1946 6. (c) If alive, give age..... years8. AGE: Years Months Days It less than one day  
6 hrs. min.9. Birthplace Scotland Md  
(Town, county, and state)10. Usual occupation None

11. Industry or business

12. Name Joseph Bryan 13. Birthplace Scotland, Md.14. Maiden name Mary Holly 15. Birthplace Scotland, Md.16. Informant Joseph Bryan  
Address Scotland Md17. Burial Date thereof Oct. 29 46  
(Burial, cremation, or removal Which?) (month) (day) (year)  
Cemetery or crematory St. Luke's Cemetery  
Location Scotland, Md.18. Funeral director Joseph Bryan  
Address Scotland, Md.19. Oct. 28 46 19.....  
(Date rec'd by registrar) Local Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 28 1946 at 2 P M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 28 1946 to Oct 28 1946 and that I last saw him alive on Oct 28 1946Immediate cause of death Naso-pharyngitis DURATION 4 days

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE pp Bryan, MD. M. D. or otherAddress Great Mills, Md. Date signed 10/28/46



2-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (732) (★)

## CERTIFICATE OF DEATH

10284

Reg. Dist. No. 2-5-6

## 1. PLACE OF DEATH:

County..... St. Mary's  
 City or town..... Bural (Clements)  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?..... 4 5 yrs  
 Hospital, institution, or street address where death occurred:.....  
 How long in hospital or institution?.....

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State..... Maryland County..... St. Mary's  
 City or town..... Clements, Md.  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No.....  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

## 3. (a) FULL NAME

Joseph Bernard Kerbert

## 3. (b) Social Security Number

4. Sex..... male 5. Color or race..... colored 6.(a) Single, married, widowed, or divorced..... widowed

6.(b) Name of husband or wife..... Jane Samuile

7. Birth date of deceased (mo., day, yr.)..... March 16 1856 6.(c) If alive, give age..... years

8. AGE: Years..... 90 Months..... 5 Days..... 4 If less than one day..... hrs. .... min.

9. Birthplace..... Maryland  
 (Town, county, and state)

10. Usual occupation..... Retired

11. Industry or business..... Farmer

12. Name..... Len Spennell

13. Birthplace..... Maryland

14. Maiden name..... Charlotte Kerbert

15. Birthplace..... Maryland

16. Informant..... Wm. Scaplan Kerbert

Address..... Clements, Md.

17. Burial Date thereof..... 10-25-46  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... St. Joseph

Location..... Morgans

18. Funeral director..... D. B. Robinson

Address..... Lionsardtown, Md.

19. 10-22 19. 46 N. V. Robinson  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

2D. DATE OF DEATH..... October 22 19. 46 at 12:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
10-17 19. 46 to 10-22 19. 46

and that I last saw him alive on 10-21 19. 46

Immediate cause of death..... Cerebral  
apoplexy

Due to..... arteriosclerosis

Due to.....

Other conditions..... similar

(Include pregnancy within 3 months of death)

Major findings of operations.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE..... Robert V. Robinson  
 M. D. or other

Address..... American, Md. Date signed..... 10-23-46

RECEIVED  
OCT 25 1946  
RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 183

## CERTIFICATE OF DEATH

10285

Reg. Dist. No. 282

## 1. PLACE OF DEATH:

County.....*St. Marys*  
 City or town.....*St. Marys City*  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....*md.* County.....*St. Marys*City or town.....*St. Marys City*  
 (If outside city or town limits, write RURAL and give nearest town)Street No.....  
 (If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (a) FULL NAME

4. Sex.....5. Color or race.....6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife.....

7. Birth date of

deceased (mo., day, yr.)

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

(Town, county, and state)

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

19.46

Registrar

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH.....*October 28* 19*46*, at *3 15* P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him..... alive on..... 19.....

Immediate cause of death.....

DURATION

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?.....

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?).....

Means of injury.....

Injured at work?.....

23. SIGNATURE.....

M. D. or other

Address.....

Date signed.....



UNITED STATES DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D. C. 20535

*Continued*

ARTICLE 1

RAC COMIT

RECEIVED  
OCT 31 1946  
BUREAU V A

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(31-2)

10286

## CERTIFICATE OF DEATH

Reg. Dist. No. 282

## 1. PLACE OF DEATH:

County St. Mary'sCity or town Lionsardtown  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution or street address where death occurred:

St. Mary's Hospital

How long in hospital or institution?

## 3. (a) FULL NAME

Alfred S. Kelly

## 3. (b) Social Security Number

## 4. Sex

male

## 5. Color or race

colored

## 6. (a) Single, married, widowed, or divorced

widowed

## 6. (b) Name of husband or wife

## 6. (c) If alive, give age \_\_\_\_\_ years

## 7. Birth date of

deceased (mo., day, yr.)

July 20, 1864

## 8. AGE:

Years

Months

Days

If less than one day

82226

hrs.

min.

## 9. Birthplace

Maryland  
(Town, county, and state)

## 10. Usual occupation

retired farmer

## 11. Industry or business

## FATHER

## 12. Name

Lee Kelly

## 13. Birthplace

Maryland

## MOTHER

## 14. Maiden name

S. Edwards

## 15. Birthplace

Maryland

## 16. Informant

Lee R. Kelly

## Address

Kellywood

## 17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

## Cemetery or crematory

## Location

## 18. Funeral director

## Address

## 19. Date rec'd by registrar

10-171946

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

## MEDICAL CERTIFICATION

## 20. DATE OF DEATH

October 16, 1946, at 1:45 A.M.

## 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Oct 9, 1946, to Oct 16, 1946and that I last saw him alive on Oct 15, 1945

## Immediate cause of death

Chronic Oudacaciditis

Due to

Due to

Other conditions

Chronic Explanitis

(Include pregnancy within 3 months of death)

## Major findings of operations

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

## 23. SIGNATURE

Address

M. D. or other

Date signed

RECEIVED  
OCT 19 1946  
BUREAU V.R.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (835)

## CERTIFICATE OF DEATH

10287

Reg. Dist. No. 281

## 1. PLACE OF DEATH:

County St. Mary's  
 City or town Valley Lee, Md  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 10 yrs  
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County St. Mary's  
 City or town Valley Lee, Md  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Sarah Amaday Knott

## 3. (b) Social Security Number

4. Sex 2. 5. Color or race W. 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Wm. Ernest Knott  
 6. (c) If alive, give age 58 years

7. Birth date of deceased (mo., day, yr.) Oct-29-1989  
 8. AGE: Years 56 Months 11 Days 9 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Hollywood, St. Mary's Co., Md  
 (Town, county, and state)

10. Usual occupation Housewife

## 11. Industry or business

12. Name Thomas Greenwell  
 13. Birthplace Md

14. Maiden name Laura Redman  
 15. Birthplace Md

16. Informant Wm. Ernest Knott  
 Address Valley Lee, Md

17. Burial Burial Date thereof 10-10-46  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory St. Johns  
 Location Hollywood, Md

18. Funeral director W. C. Mattingley Sons  
 Address Leonardtown, Md

19. Oct 9 1946 W. C. Mattingley Registrar  
 (Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH Oct-8-46 1946, at 11:10 A., M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 10 1946 to Oct 8 1946  
 and that I last saw him/her alive on Oct 7 1946

Immediate cause of death	DURATION
<u>Central nervous system</u>	<u>3 hrs</u>
<u>General arteriosclerosis</u>	<u>14 yrs</u>
Due to _____	_____
Due to _____	_____
Other conditions _____	_____
(Include pregnancy within 8 months of death)	

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)  
 Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
 Means of injury \_\_\_\_\_ Injured at work?

23. SIGNATURE W. C. Mattingley M. D. or other \_\_\_\_\_  
 Address Great Mills, Md Date signed Oct 9/46

RECEIVED  
OCT 17 1946  
BUREAU V.B.

M

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (31-2)

## CERTIFICATE OF DEATH

10288

Reg. Dist. No. 282

## 1. PLACE OF DEATH:

County St. Mary'sCity or town Lansdown  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution or street address where death occurred:

St. Mary's Hospital

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County St. Mary'sCity or town Lansdown  
(If outside city or town limits, write RURAL and give nearest town)Street No. 6  
(If rural, give LOCATION)2.(a) If veteran, name war 6

## 3. (a) FULL NAME

Eugene Curtis Peck

## 3. (b) Social Security Number

4. Sex male5. Color or race white6. (a) Single, married, widowed, or divorced married6. (b) Name of ~~husband~~ or wife Katharine S.H. Peck6. (c) If alive, give age 53 years7. Birth date of deceased (mo., day, yr) February 5, 18958. AGE: Years 51 Months 8 Days 4 If less than one day

.....hrs. ....min.

9. Birthplace New Britain, Conn.  
(Town, county, and state)10. Usual occupation Doctor of Medicine11. Industry or business Robert H. Peck12. Name Robert H. Peck13. Birthplace Bridgeport, Conn.14. Maiden name Helen L. Curtis15. Birthplace Penn.16. Informant Mr. Katharine S.H. PeckAddress H. Clements Shaw, M.D.17. Interment Date thereat 10-12-1946  
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory J. H. L. & SonsLocation Washington, D. C.18. Funeral director F.D. RobinsonAddress Lansdown, Maryland.19. 10/11 46 Chaucer  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 9 19 46 at 8:20 P M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 6 19 46 to Oct. 9 19 46and that I last saw him alive on Oct. 9 19 46Immediate cause of death Congestive Heart Failure.Due to HypertensionDue to Chronic Nephritis.Other conditions Empyema Right Chest.

(Include pregnancy within 3 months of death)

Major findings of operations.....Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of Injury Injured at work?

23. SIGNATURE Mr. H. Peck M.D. M. D. or otherAddress Pearson M.D. Date signed 10-9-46

MARGIN RESERVED FOR BINDING

I

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

OCT 14 1946

BUREAU V. S.



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 282

## 1. PLACE OF DEATH:

County St Marys  
City or town Lemondtown Md  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 2 hours

Hospital, institution, or street address where death occurred:

Lemondtown MdHow long in hospital or institution? St Marys Hospital

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County St MarysCity or town Hermanville Md  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Herbert Thompson Shannon

## 3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced married6.(b) Name of husband or wife Ethel Foster7. Birth date of deceased (mo., day, yr.) March 18 - 1883 6.(c) If alive, give age 54 years8. AGE: Years 63 Months 7 Days 14 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace Washington D.C.  
(Town, county, and state)10. Usual occupation Real Estate

11. Industry or business \_\_\_\_\_

12. Name James Shannon13. Birthplace Baltimore Md14. Maiden name Mary Laura Preston15. Birthplace Baltimore Md16. Informant Mrs Ethel F ShannonAddress Hermanville Md17. Burial Date thereof Nov 9 - 1946  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Park Creek CemeteryLocation Washington D.C.18. Funeral director W.C. Mattingley SonsAddress Lemondtown Md19. 10/31/46 Registrar Carroll

(Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH October 31 19 46 at 9 P. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 13 19 44 to October 21 19 46and that I last saw him alive on October 21 19 46Immediate cause of death Cerebral Hemorrhage

DURATION

2 hoursDue to Malignant Hypertension2 yearsDue to Generalized Atherosclerosis

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Dr. H. Patrick M.D.Address Pearson road M. D. or other \_\_\_\_\_Date signed 10/31-46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1088

MASSACHUSETTS DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

RECEIVED  
NOV 4 1946  
BUREAU A.C.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

★ 10290

Reg. Dist. No. 287

## 1. PLACE OF DEATH:

County St. Mary's  
 City or town Drayden Md  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 13 years  
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County St. Mary's  
 City or town Drayden  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)

2. (a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Hannie M. Shorter

## 3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

F W married

6. (b) Name of husband or wife Albert L. Shorter

7. Birth date of deceased (mo., day, yr.) July 27 - 1892  
 6. (c) If alive, give age 61 years

8. AGE: Years 54 Months 2 Days 25 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Valley Lee St. Mary's Maryland  
 (Town, county, and state)

10. Usual occupation house wife

11. Industry or business

12. Name William Hammett13. Birthplace St. Mary's Co14. Maiden name Catharine Brown15. Birthplace St. Mary's Co16. Informant Albert L. ShorterAddress Drayden Md17. Burial Date thereof Oct 24, 1946

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Poplar Hill cemeteryLocation Valley Lee Md18. Funeral director W. C. Mattingly SonsAddress Leonardtown Md19. Oct 23 1946 Registrar

(Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 22 1946 at 6:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Oct 16 1946 to Oct 22 1946and that I last saw him alive on Oct 21 1946Immediate cause of death Cerebral infarction

DURATION

24 hours

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE P. J. Miller M. D. or otherAddress Cent. Mill Md Date signed Oct 24/46

RECEIVED  
NOV 2 1946  
BUREAU V R

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

10291

Reg. Dist. No. 252

## 1. PLACE OF DEATH:

County St. Marys  
 City or town near Bushwood  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County St. Marys  
 City or town Bushwood  
 (If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Wm. Matthias Thompson

## 3. (b) Social Security Number

213-32-0088

4. Sex

male

5. Color or race

Caf.

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife

Mary M. Thompson

7. Birth date of deceased (mo., day, yr.)

May 11, 19036. (c) If alive, give age 38 years

8. AGE:

Years

Months

Days

If less than one day

4359

hrs.

min.

9. Birthplace

Maryland

(Town, county, and state)

10. Usual occupation

Labo

11. Industry or business

Md. State Road Comm.

MOTHER

FATHER

12. Name

John Thompson

13. Birthplace

Maryland

14. Maiden name

Anne Young

15. Birthplace

Maryland

16. Informant

Mary M. Thompson

Address

Bushwood, Md.

17. Burial

(Burial, cremation, or removal) Which?

Date thereof

10-23-46

(month) (day) (year)

Cemetery or crematory

Sacred Heart

Location

Bushwood, Md.

18. Funeral director

P.B. Robinson

Address

Leonardtown, Md.

19. 10-22

(Date rec'd by registrar)

1946

canalier

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH

Oct 20th 1946 at 60 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Saw the deceased to Oct 20 19 46

and that I last saw him alive on

19

Immediate cause of death

Internal Hemorrhage of chest and abdomen and other injuries

DURATION

10 min

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Accident

Date of

Oct 20 46

Where did injury occur?

Highway 248

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Struck by automobile

at work?

no

23. SIGNATURE

Francis F. Greenwell

M. D. or other

Address

Leonardtown, Md.

Date signed

Oct 20 46

1968

RECEIVED  
JUL 24 1968  
F. A. OVERHEAD F. A.

*Artesian*  
ARTESIAN LEADER  
FACTORY



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (108)

## CERTIFICATE OF DEATH

 10292  
 ★  
 Reg. Dist. No. 281

## 1. PLACE OF DEATH:

County St. MarysCity or town Rural Park Hall  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 1 month

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County St. MarysCity or town Rural Park Hall  
(If outside city or town limits, write RURAL and give nearest town)Street No. 1/2 mile east of Park Hall  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Harry Shelton Loney

## 3. (b) Social Security Number

4. Sex Male5. Color or race Black6.(a) Single, married, widowed, or divorced single

6.(b) Name of husband or wife

8.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 19/46

8. AGE: Years Months Days If less than one day

hrs. min.

9. Birthplace Park Hall Md  
(Town, county, and state)10. Usual occupation none

11. Industry or business

12. Name Theodor Fenwick13. Birthplace Park Hall, Md14. Maiden name Ginnie Loney15. Birthplace California, Md16. Informant Theodor FenwickAddress Park Hall, Md17. Burial Date thereof Oct 21/46  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory St James CemeteryLocation Park Hall Md18. Funeral director Theodor FenwickAddress Park Hall Md19. Oct 20 1946 Registrar James

(Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 20 1946 at 9:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Oct 20 1946 to Oct 20 1946and that I last saw him alive on Oct 20 1946Immediate cause of death Brain pneumonia

## DURATION

2 days

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE James M.D. or otherAddress Park Hall, Md Date signed Oct 20/46



1946

MASSACHUSETTS DEPARTMENT OF HEALTH

501 N. GARDEN STREET, BOSTON 18, MASS.

CERTIFICATE OF DEATH

THE DEPARTMENT OF HEALTH, STATE OF MASSACHUSETTS

REPORT OF DEATH

NOV 2 1946  
BUREAU V R

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (31-2)

## CERTIFICATE OF DEATH

10293

Reg. Dist. No. 282

### 1. PLACE OF DEATH:

County St. Mary's  
City or town Severington Park, Maryland  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 2 months  
Hospital, institution, or street address where death occurred:  
#3 Tanner ave  
How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State South Dakota County Haskell  
City or town Philip  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. \_\_\_\_\_  
(If rural, give LOCATION)  
2. (a) If veteran, name war \_\_\_\_\_

### 3. (a) FULL NAME

Jake Weber

### 3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced widowed

6. (b) Name of husband or wife Emily Keeling

7. Birth date of deceased (mo., day, yr.) Aug. 21 1868 6. (c) If alive, give age \_\_\_\_\_ years

8. AGE: Years 78 Months 2 Days 6 it less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

8. Birthplace Manteno Illinois State  
(Town, county, and state)

10. Usual occupation Shoe maker

11. Industry or business

12. Name unknown

13. Birthplace

14. Maiden name unknown

15. Birthplace

18. Informant Paul Robert Weber

Address #3 Tanner ave Severington Park Md

17. Burial Date thereof Nov 1 1946  
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Philip Cemetery

Location Haskell co South Dakota

18. Funeral director W. C. Mattingley, Sons

Address Severington Maryland

19. 10/28/46 Registrar  
(Date rec'd by registrar)

### MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 27 19 46 at 8:45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 2 19 46 to Oct 27 19 46 and that I last saw him alive on Oct 26 19 46

Immediate cause of death \_\_\_\_\_ DURATION \_\_\_\_\_

Chronic Deleterious Heart Disease 4 yrs

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions Intermittent Nephritis 2 years

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE W. C. Mattingley M. D. or other \_\_\_\_\_

Address Severington Md Date signed 10/28/46

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
OCT 30 1946  
BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PARENTS: W.VA. BIRTH REGISTRATION NOTIFICATION VERIFYING BELOW, plus statement of  
mother relative to items **MARYLAND STATE DEPARTMENT OF HEALTH**  
13 and 15, filmed 4-10-47 G109 LL 2411 N. Charles St., Baltimore (70)

# CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
County..... St. Marys				(For newborn infants give residence of mother)			
City or town..... On Rt. 235, 1 mile from NAS, Patuxent River, Md.				City or town..... New York City			
(If outside city or town limits, write RURAL and give nearest town)				(If outside city or town limits, write RURAL and give nearest town)			
How long in above place of death?.....				Street No..... 218 E. 11th Street			
Hospital, institution, or street address where death occurred:				(If rural, give LOCATION)			
How long in hospital or institution?.....				2.(a) If veteran, name war.....			
3. (a) FULL NAME				3. (b) Social Security Number			
WILEY, Claude Jr.							
4. Sex		5. Color or race		6. (a) Single, married, widowed, or divorced			
Male		White		Married			
6. (b) Name of husband or wife..... Sara Wiley (Bookin)							
7. Birth date of deceased (mo., day, yr.)..... 1-30-22				6. (c) If alive, give age..... years			
8. AGE:		Years		Months		Days	
24		8		4		If less than one day	
						hrs. min.	
9. Birthplace..... West Virginia				(Town, county, and state)			
10. Usual occupation..... Pharmacist Mate							
11. Industry or business..... U. S. Navy							
FATHER		12. Name..... Unknown		13. Birthplace..... Unknown		14. Maiden name..... Unknown	
MOTHER		15. Birthplace..... Unknown		16. Informant..... U.S.Navy		Address..... Patuxent River, Md.	
		17. Removal.....		Date thereof..... 10/5/46		(month) (day) (year)	
		(Burial, cremation, or removal. Which?)		Cemetery or crematory.....		Location..... Sandstone, West Virginia	
		18. Funeral director..... P.B.Robinson		Address..... Leonardtown, Md.		10/5-46	
		19. (Date rec'd by registrar)		19. 46		Registrar.....	
20. DATE OF DEATH..... 4 October 19. 46 at 3:50 A.M.				21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Not attended 19. to 19. and that I last saw him alive on 4 October 19. 46			
Immediate cause of death..... Injuries, multiple: Extreme				DURATION			
Due to..... Fracture, skull, occiput							
Due to.....							
Other conditions.....				(Include pregnancy within 8 months of death)			
Major findings of operations.....				Date of op.....			
Autopsy results..... Injuries, multiple, extreme				PHYSICIAN: Please underline the cause to which death should be charged statistically.			
22. VIOLENCE: If death was due to external causes, fill in the following:				Accident, suicide, or homicide..... accident Date of..... 10-4-46			
Where did injury occur?..... Rt. 235, 1 mi. from NAS, St. Marys, Md.				(City or town) (County) (State)			
Injured at home, farm, industry, public place (where?)..... Public highway				Means of Injury..... Automobile Injured at work? No			
23. SIGNATURE..... FRANK A. CERZOSIMO, Lt. (MC) USN				M. D. or other			
Address..... US NAS, Patuxent River, Md.				Date signed..... 10-4-46			

REC'D  
OCT 8 1946  
BUREAU